STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495410	A. BUILDING _____ B. WING _____	11/13/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARLEIGH BURKE PAVILION	1739 KIRBY ROAD MC LEAN, VA 22101

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 11/12/15 to 11/13/15. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety code survey/report will follow. The census in this 49 certified bed facility was 47 at the time of the survey. The survey sample consisted of 11 current resident reviews (Residents #1 through #11) and four closed record reviews (Residents #12 through #15).	F 000	F 441 Both ice machine drain pipes (one in main kitchen and one in short-term rehabilitation unit) were both corrected on-site before the survey exit on 11/13/15. A facility wide audit has been conducted to ensure proper back flow prevention and no additional drain pipes exist. The facility's procedure for monitoring infection control procedures related to the air gap clearance from an ice machine to the drain has been reviewed. The Quality Assurance tool "Dietary Kitchen Inspection" identifies drains and ice machine variables as a monitoring component of the QA program and clearly asks if the ice machine drain has a 1 inch air gap of clearance to the drain. Those personnel responsible for monitoring the kitchen equipment as it relates to drains and ice machines have been educated on using the "Dietary	12/18/15
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 11/23/2015

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 441	Continued From page 1 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain an air gap for two of three ice machines available for use. The findings include: Observation was made on 11/12/15 at 9:27 a.m. of the kitchen, accompanied by other staff member (OSM) #2, the dietary manager. The ice machine was observed. The drain pipe, approximately one inch in diameter, was sitting directly on the drain grate, on the floor. When asked if the drain was located in the proper position, OSM #2 stated, "No something must be hitting it or something, it's supposed to be above the drain." Observation was made on 11/12/15 at approximately 10:00 a.m. of the kitchen on the acute rehabilitation wing. The ice machine drain was an approximately, two inch in diameter, pipe.	F 441	Kitchen Inspection" tool for QA monitoring purposes. The Dietary Services Coordinator and/or designee will utilize the "Dietary Kitchen Inspection" tool on a weekly basis as part of the routine QA monitoring schedule. Any further infractions will be reported to the QA committee for evaluation. F504 A clarification order was obtained from the attending physician for a Vitamin B 12 level for resident #6. A care plan was added for resident #6.	12/18/15

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F 441	Continued From page 2 A grate was covering the drain. The pipe extended down inside the drain by approximately two to three inches. When asked if the drain was in the correct position, OSM #2 stated, "That's the way it was when we had our opening inspection. But ice drains have to be protected from backflow." United States Public Health Food Code; 5-202.13 Backflow Prevention, Air Gap. An air gap between the water supply inlet and the flood level rim of the PLUMBING FIXTURE, EQUIPMENT, or nonFOOD EQUIPMENT shall be at least twice the diameter of the water supply inlet and may not be less than 25 mm (1 inch). P The administrator and director of nursing were made aware of these findings on 11/12/15 at 5:47 p.m.	F 441	A facility wide audit of all residents has been completed to ensure physician orders and care plans are present for those residents who require laboratory services. The facility policy on transcription of orders as well as 24 hour chart checks has been reviewed and the 24 hour chart check policy has been amended. The licensed nurse responsible for the 24 hour chart check will ensure that all new orders entered into the electronic medical record are transcribed correctly while also ensuring that all laboratory services have a corresponding physician order. All licensed nurses have been re-inserviced on the transcription of orders policy and inserviced on the change in the 24 hour chart check policy.	
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN The facility must provide or obtain laboratory services only when ordered by the attending physician. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to obtain a physician order prior to obtaining a laboratory test for one of 14 residents in the survey sample, Resident #6. The facility staff obtained a Vitamin B 12 level (measures the Vitamin B 12 level in your blood) without a physician's order.	F 504		

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 504	Continued From page 3 The findings include: Resident #6 was admitted to the facility on 3/14/11 with diagnoses that included but were not limited to: high blood pressure, insomnia, vitamin B 12 deficiency, dry eye, gastroesophageal reflux disease, hypothyroid, and neuropathy. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/8/15, coded the resident as scoring a 13 on the BIMS (brief interview for mental status) score indicating the resident as cognitively intact to make daily decisions. The resident was coded as requiring supervision to extensive assistance for most of his activities of dally living. Review of the clinical record revealed a laboratory test result dated, 2/5/15 for a Vitamin B 12 level. Review of the physician order summary for February 2015, signed by the physician on 2/1/15, documented, "CBC (complete blood count), CMP (comprehensive metabolic panel) for B 12 Deficiency annually in Feb (February)." Review of the February 2015 TAR (treatment administration record) documented, "Labs (laboratory tests) CBC, CMP for B 12 deficiency." It was documented as completed on 2/5/15. Review of the comprehensive care plan did not document anything related to laboratory tests. At the end of the day meeting on 11/12/15, the director of nursing (DON) was asked for the physician order for the Vitamin B 12 level done	F 504	The Director of Nursing and/or designee will audit all new physician orders on a weekly basis to ensure they are complete while also ensuring all laboratory services have a corresponding physician's order. Any further infractions will be reported to the QA committee for evaluation.	

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F 504	Continued From page 4 2/5/15. On 11/13/15, the administrator was asked again for the copy of the order for the lab test done on 2/5/15. The administrator stated, "I can't find anything. We only have a pharmacy recommendation in 2013 that mentions a Vitamin B 12 level." The physician orders for February 2015 and the TAR for February 2015 were reviewed with the administrator. She stated, "No, there is nothing I can give you that has an order for that." The pharmacy recommendation was written on with no physician signature. The DON (director of nursing) presented a copy of a policy but the policy was not related to Vitamin B 12 levels, it related to the testing and reporting of laboratory tests related to clotting. No further information was provided prior to exit.	F 504		